MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11159

CERTIFICATE OF DEATH

Reg. Dist. No. 314

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring (outside)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montg.

City or town: Silver Spring R.F.D.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1970 Capitol View Ave

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: Felix Eugene Averill

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Susanna Averill

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): July 21 1894

8. AGE:

Years	Months	Days	If less than one day
51	3	19	____ hrs. ____ min.

9. Birthplace: Syracuse N.Y. (Town, county, and state)

10. Usual occupation: Special agent in

11. Industry or business: Home & education. &c.

FATHER

12. Name: Francis E. Averill

13. Birthplace: N.Y.

MOTHER

14. Maiden name: Kate Howe

15. Birthplace: N.Y.

16. Informant: Susanna Averill

Address: 1970 Capitol View Ave - Silver Spring Md

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: Nov. 12 1945 (month) (day) (year)

Cemetery or crematory: Fort Lincoln.

Location: Prince Georgis Co. Md

18. Funeral director: James E Pumphrey

Address: 8453 Ga Ave - Silver Spring. Md

19. Nov. 13 1945 (Date rec'd by registrar) Josephine McHaffie Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 10 19 45, at 11:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1945 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary occlusion	Unknown suddenly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: Frank J. Bernhart M.D. M. D. or other

Address: Gaithersburg Md Date signed 11-10-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

11160

CERTIFICATE OF DEATH

Reg. Diat. No. 218

1. PLACE OF DEATH:
County Montgomery
City or town Rockville Md- Route 1
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Montgomery
City or town Rockville, Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. Route 1
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Regina A. Baker

3.(b) Social Security Number —

4. Sex: female
5. Color or race: white
6.(a) Single, married, widowed, or divorced: widowed
6.(b) Name of husband or wife: Reuben Baker
8.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): June 3, 1863
8. AGE: Years 80 | Months 5 | Days 10 | If less than one day ... hrs. ... min.
9. Birthplace: Page Co., Va (Town, county, and state)
10. Usual occupation: house-keeping
11. Industry or business: at home
FATHER 12. Name: Elisha Pettit
FATHER 13. Birthplace: unknown
MOTHER 14. Maiden name: unknown
MOTHER 15. Birthplace: unknown
16. Informant: Pearie S. Beahm
Address: Rockville, Md- R-1
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 15 1945 (month) (day) (year)
Cemetery or crematory: New Market Va
Location: Shenandoah Co
18. Funeral director: Roy W. Barber
Address: Ft Tonsville md
19. Nov. 14 1945 (Date rec'd by registrar) Abner J. Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov - 13 - 1945 at 2.45 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec - 1942 to Nov - 13 - 1945 and that I last saw her alive on Nov - 10 - 1945

	DURATION
Immediate cause of death: Cardio-nephritis	6 mo
Due to: Diabetes	10 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: William C. Miller, M.D. or other
Address: Gaithersburg, Md Date signed 11/3/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11161

★ Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Monty.

City or town: Bethesda Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Suburban Hosp. 2½ hrs.

Hospital, Institution, or street address where death occurred: Suburban Hosp.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Monty.

City or town: Rockville, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 206 Reading Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Clara M. Barnes

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married.

6.(b) Name of husband or wife: Oliver C.

6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): Oct. 20, 1873

8. AGE: Years	Months	Days	If less than one day
72	0	13	....hrs. ....min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Daniel R. Meredith

FATHER — 13. Birthplace: Baltimore, Md.

MOTHER — 14. Maiden name: Ann Rebecca Sherwood

MOTHER — 15. Birthplace: Baltimore, Md.

16. Informant: Rev. Oliver C. Barnes

Address: 206 Reading Ave. Rockville

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11/7/45 (month) (day) (year)

Cemetery or crematory: Louden Park Cem.

Location: Baltimore, Md.

18. Funeral director: Wm Reuben Pumphrey

Address: Bethesda, Md.

19. 11/7 19 45 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 3 19 45, at 4:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. Med. Exam Case 19 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Shock	1½ hrs
Due to: Crushed pelvis and internal hemorrhage	
Due to: struck by train	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 11-3-45

Where did injury occur? Rockville (City or town) Monty (County) Md (State)

Injured at home, farm, industry, public place (where?): B+O RR

Means of injury: Struck by Train Injured at work? no

23. SIGNATURE: Frank J. Broschart M.D. Dep. Med. Exam. M. D. or other

Address: Gaithersburg Md. Date signed: 11-3-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30)

CERTIFICATE OF DEATH

11163

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 days

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Mass. County:

City or town: Cambridge

(If outside city or town limits, write RURAL and give nearest town)

Street No. 25 Market St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: BISHOP, Richard Fredrick, GMlc USN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mary A. Bishop

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 4 Nov. 1917

8. AGE:	Years	Months	Days	If less than one day
	28	0	24	hrs. min.

9. Birthplace: Ohio (Town, county, and state)

10. Usual occupation: U.S. Navy

11. Industry or business:

FATHER — 12. Name: Harry L. Bishop

13. Birthplace: Mich.

MOTHER — 14. Maiden name: Jessie M. Ford

15. Birthplace: Ohio

16. Informant: Wife: Mrs. Mary A. Bishop

Address: 25 Market St., Cambridge, Mass.

17. removal (Burial, cremation, or removal. Which?) Date thereof: 11-28-45 (month) (day) (year)

Cemetery or crematory:

Location: Cleveland, Ohio

18. Funeral director: Geo. W. Wise, D.C.F.

Address: 2900 M St., N. W., Wash., D.C.

19. 11-28 (Date rec'd by registrar) 19 45 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 28 Nov 1945 at 13:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 15 Nov. 1945 to 28 Nov. 1945 and that I last saw him alive on 28 Nov. 1945

Immediate cause of death: acute hemorrhagic nephritis — DURATION: 10 days

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: C. H. C. Smith, Comdr. (MC) USNR

M. D. or other

Address: US N.H., Bethesda, Md. Date signed: 11-28-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83(a)

CERTIFICATE OF DEATH

11164

Reg. Dist. No. 2 13

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Darnestown (Rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 yrs.

Hospital, Institution, or street address where death occurred: R.F.D. #3 Gaithersburg Md

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Darnestown

(If outside city or town limits, write RURAL and give nearest town)

Street No. R.F.D. #3 Gaithersburg Md

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Catherine E. Bogley

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Henry W. Bogley.

B.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): Sept. 9, 1883

8. AGE:

Years	Months	Days	If less than one day
62	1	22	...hrs. ...min.

9. Birthplace: Baltimore Maryland (Town, county, and state)

10. Usual occupation: Home wife

11. Industry or business: Housekeeping

FATHER 12. Name: George Whitefield

FATHER 13. Birthplace: Maryland

MOTHER 14. Maiden name: Mary McCooker

MOTHER 15. Birthplace: Maryland

16. Informant: Mrs. L. B. Gregue

Address: Rockville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 3-1945 (month) (day) (year)

Cemetery or crematory: New Cathedral Cem. Baltimore

Location: Baltimore Md.

18. Funeral director: W. Reuben Pumphrey

Address: Rockville Maryland

19. Nov. 3, 1945 (Date rec'd by registrar) Upton D. Stouse M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 1st 1945, at 11 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 31st (5 P.M.) 1945, to Nov. 1st 1945, and that I last saw her alive on Nov 1st 1945.

Immediate cause of death	DURATION
(Regta Comitis Hegis) Cerebreal Hemorrhage	17 hrs
Due to: Genl arterial Sclerosis	10 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Upton D Stouse M.D. M. D. or other

Address: Darnestown Md Date signed: 11/2/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11165

Reg. Dist. No. 24

1. PLACE OF DEATH:

County: Montgomery

City or town: Olney, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

The Montgomery County General Hospital

How long in hospital or institution? 16 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Gaithersburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. R#2

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: James Bright

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: none

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): June 22. 1889

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
56	4	27		

9. Birthplace: Maryland

(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Farm.

FATHER — 12. Name: William Bright

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Annie Washington

MOTHER — 15. Birthplace: Md

16. Informant: Hospital records.

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 21 1945 (month) (day) (year)

Cemetery or crematory: Brook Grove Md

Location: Montgomery Co Md

18. Funeral director: Roy W. Barber

Address: Laytonsville Md

19. 11-21- 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 18 1945, at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 2 1945, to Nov. 18 1945

and that I last saw him alive on Nov. 18 1945

Immediate cause of death	DURATION
Lobar Pneumonia	16 days
Due to	
Due to	
Other conditions Chr. nephritis (Include pregnancy within 3 months of death)	Unknown

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Elias Bamberger M. D. Coroner

Address: Sandy Spring Md Date signed: 11/13/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Reuben Pumphrey

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

Reg. Dist. No. 216

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 days

Hospital, Institution, or street address where death occurred:
Suburban Hospital - 8600 Old Georgetown (Rd.)

How long in hospital or institution? 7 days Bethesda, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4411 Stanford
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mr. ~~James~~ John S Bullock

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mollie Bullock

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 26, 1875

8. AGE:	Years	Months	Days	If less than one day
	70	6	19	..... hrs. ..... min.

9. Birthplace McDonough Co. Illinois
(Town, county, and state)

10. Usual occupation Sales man

11. Industry or business

FATHER
12. Name James Bullock
13. Birthplace ? Scotland

MOTHER
14. Maiden name Caroline Conn
15. Birthplace ? Illinois

16. Informant Wife

Address 4411 Stanford - Chevy Chase Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/15/45 (month) (day) (year)

Cemetery or crematory Rockville Union Cem

Location Rockville Md.

18. Funeral director Wm Reuben Pumphrey

Address Bethesda Md.

19. 11/15 19 45 Wm E Jobes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-13-45 19 ..... at 7 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-9-44 19 ..... to 11-13 19 45

and that I last saw h.l.m. alive on 11-13 19 45

Immediate cause of death	DURATION
Registory failure	
Due to Cardio vascular renal disease & uremia	
Due to Valvular heart disease and arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Frank Jaggers M.D.
M. D. or other

Address 8016 Georgetown Rd. Date signed 11/15/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157)

11167

CERTIFICATE OF DEATH

Reg. Dist. No. 2-66

1. PLACE OF DEATH:

County: Montgomery

City or town: Rural — Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Suburban Hosp. - Jer. Rd -

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: — County:

City or town: Washington DC

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3707 - Brandywine St. N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Charles Drewry Bufford Jr. -

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	—

B.(b) Name of husband or wife —

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 6 - 1945

8. AGE: Years | Months | Days | If less than one day: 16 hrs. 46 min.

9. Birthplace Bethesda Montgomery Maryland (Town, county, and state)

10. Usual occupation NONE

11. Industry or business NONE

FATHER 12. Name Charles Drewry Bufford Sr.

FATHER 13. Birthplace Norfolk Virginia

MOTHER 14. Maiden name Kathryn Jane Murphy

MOTHER 15. Birthplace Washington D.C.

16. Informant Kathryn Jane Bufford

Address 3707 - Brandywine St. N.W. DC

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-8-45 (month) (day) (year)

Cemetery or crematory Mt. Olivet Cemetery

Location Wash. D.C.

18. Funeral director T. F. Costello

Address 1722 - N. Cap. St. Wash. D.C.

19. 11/8 1945 Wm E Jolley Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November - 7 - 1945, at 4:06 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 6, 1945, to November 7 1945 and that I last saw him alive on November 7 1945

Immediate cause of death	DURATION
PREMATURE ATELECTASIS.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op.

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE P. D. Andrews M.D. M. D. or other

Address 4201 Forrester St. N.W. Date signed 11-7-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

11168

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: 4608- W. Va, Ave Bethesda, Md.
City or town: (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: County:
City or town: Bethesda, Md. (If outside city or town limits, write RURAL and give nearest town)
Street No.: 4620 W. 6th St N.E. Ave (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mary E. Butler

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Richard T.
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 14, 1866

8. AGE: Years: 79 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: William E. Hall
13. Birthplace: Virginia

MOTHER
14. Maiden name: ?
15. Birthplace: ?

16. Informant: Mrs Viola B. Costenbarder
Address: 2620- 6th St N.E. (Daughter

17. Burial (Burial, cremation, or removal, Which?) Date thereof: Nov. 7- 1945 (month) (day) (year)
Cemetery or crematory: Cedar Killeen Nov 7 1945
Location:

18. Funeral director: The S. H. Hines Co
Address: 2201-14-st N.W. Washington, D.C.

19. Nov 5 1945 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11/4/ 1945 at 4 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from [illegible] 1945, to Nov 4 1945
and that I last saw h[illegible] alive on Nov 4 1945

Immediate cause of death	DURATION
Cardiac Failure	1 hr
Due to: Myocarditis	1 yr
Due to: Arteriosclerosis	3 yrs
Due to: Diabetis	5 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R. H. Tangaras (Manganaro) M.D. M. D. or other
Address: 140- Maple Ave NW Date signed: 11/4/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

CERTIFICATE OF DEATH

11169

Reg. Dist. No. 221

1. PLACE OF DEATH:
County: Montgomery
City or town: Takoma Pk.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?:
Hospital, institution, or street address where death occurred:
100-Baltimore Ave.
How long in hospital or institution?:

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 734 Rittenhouse St-N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Emanuele Cavaliere

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Domenica Cavaliere
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August-23-1851

8. AGE: Years	Months	Days	If less than one day
94			hrs. min.

9. Birthplace: Italy
(Town, county, and state)
10. Usual occupation: Retired
11. Industry or business:

FATHER
12. Name: Emanuele Cavaliere
13. Birthplace: Italy

MOTHER
14. Maiden name: ?
15. Birthplace: ?

16. Informant: Fred Cavaliere (Washington)
Address: 734 Rittenhouse St-N.W.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov-21-45 (month) (day) (year)
Cemetery or crematory: St-Marys
Location: Washington-D.C.

18. Funeral director: Deal Funeral Home
Address: 4812-Georgia Av. Washington-D.C.

19. Nov. 19 1945 (Date rec'd by registrar) J Nelson Todd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November-19-45, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/2/45 19 to 11/19/45 19 45
and that I last saw h alive on 11/19/45 19
Immediate cause of death: Myocarditis — DURATION 2 yrs.
Due to: old age
Due to: Natural cause.
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: R. N. Manganaro M.D.
M. D. or other
Address: 1410-Mass-Av. D.C. Date signed: 11/19/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1229

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11170

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: MONTGOMERY

City or town: BETHESDA MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 Yrs 6 MOS

Hospital, institution, or street address where death occurred:
SUBURBAN

How long in hospital or institution? 1 Yr 6 HRS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: WASHINGTON County: D.C.

City or town: "
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2700 WISCONSIN AVE N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

MRS HARMON CHALLENGER

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	MARRIED

6.(b) Name of husband or wife: HAROLD L. CHALLENGER

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): DEC. 15, 1891

8. AGE: Years	Months	Days	If less than one day
53	11	1	____ hrs. ____ min.

9. Birthplace: CHICAGO ILL COOK CO.
(Town, county, and state)

10. Usual occupation: HOUSEWIFE

11. Industry or business:

FATHER
12. Name: EDWARD P. BAILEY
13. Birthplace: MICHIGAN

MOTHER
14. Maiden name: MINERVA SPRUANCE
15. Birthplace: CHICAGO ILL.

16. Informant: HOSP RECORDS
Address:

17. Cremation (Burial, cremation, or removal. Which?) Date thereof Nov. 16, 1945 (month) (day) (year)

Cemetery or crematory: Arlington Cem.
Location: Va

18. Funeral director: Jos Gawler's Sons
Address: 1756 Pa Ave NW Wash DC

19. 11/16 1945 (Date rec'd by registrar) Wm E. Jabes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 16 1945, at 12:25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 15 1945 to Nov 16 1945 and that I last saw h[illegible] alive on Nov 16 1945

Immediate cause of death	DURATION
Virus (atypical) pneumonia	5 days
Due to: Cardiac decompensation & pulmonary edema	12 hours
Due to:	
Other conditions: Chronic bronchial asthma	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.:

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Edward Hughes M. D. or other

Address: 1726 Eye St. N.W. Date signed: 11/16/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

11171

FILM No. I 01 APR - 9 1946

CERTIFICATE OF DEATH

Reg. Diat. No. 218

1. PLACE OF DEATH:
County: Montg Co,
City or town: Gaithersburg Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 19yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montg
City or town: Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Miss Mamie E Childs

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 15th 1872

8. AGE: Years	Months	Days	If less than one day
73 ~~1872-72~~	5	28	hrs. min.

9. Birthplace: Winchester Va,
(Town, county, and state)
10. Usual occupation: Seamstress
11. Industry or business

FATHER
12. Name: John A Childs
13. Birthplace: Va,

MOTHER
14. Maiden name: Mary E CBlues
15. Birthplace: Va,

16. Informant: Methodist Home, H M Wilson
Address: Gaithersburg Md,

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/16/45 (month) (day) (year)
Cemetery or crematory: Mt Hebron Cemetery
Location: Winchester, Va,

18. Funeral director: Ernest C Gartner
Address: Gaithersburg Md,

19. Nov 15 1945 (Date rec'd by registrar) Amanda G Cook Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 13th 1945 at 9.05 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1945 to Nov 13 1945 and that I last saw h.. alive on Nov 13 1945

Immediate cause of death: Coronary occlusion — DURATION: 20 min
Due to: Diabetes
Due to:
Other conditions: Atrophic arthritis? Arteriosclerosis
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Gathree E Kuhn M.D
M. D. or other
Address: Rockville Md Date signed 11/16/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11172

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:

County: Montgomery

City or town: Trawbah - R.F.D. - Rockville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Trabbah - Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.: R.F.D. #1 - Rockville

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Louis David Connelly

3. (b) Social Security Number: 214-12-7204

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Dorothy Lowe Connelly

6.(c) If alive, give age: 34 years

7. Birth date of deceased (mo., day, yr.): December 15 - 1903

8. AGE: Years: 39 | Months: 11 | Days: 4 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Montgomery Co - Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER 12. Name: Patrick Connelly

FATHER 13. Birthplace: Mont. Co - Maryland

MOTHER 14. Maiden name: Catharine Hadley

MOTHER 15. Birthplace: Montg Co - Maryland

16. Informant: Mrs. Dorothy Lowe Connelly

Address: R.F.D. #1 Rockville - Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 21/45 (month) (day) (year)

Cemetery or crematory: Presbyterian Church Cem.,

Location: Damascus - Maryland

18. Funeral director: Wm. Reuben Pumphrey

Address: Rockville - Maryland

19. 11/20/45 (Date rec'd by registrar) Josephine D. Hatton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 19 1945 at 4 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940, to Nov. 19 1945

and that I last saw him alive on about July 1945

Immediate cause of death: Pulmonary Tuberculosis — DURATION: at least 5 years

Due to:

Due to:

Other conditions: (Pronounced dead by Dr. E. V. Hartley, Rockville, Md.)

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.:

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Wm. R. Stallings M.D. (M. D. or other)

Address: Rockville, Md. Date signed 11/19/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (22-E)

11173

CERTIFICATE OF DEATH

Reg. Dist. No. 714

1. PLACE OF DEATH:

County Montgomery

City or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? —

~~Hospital, institution, or~~ street address where death occurred:

10,604 So. Dunmoor Drive

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 10,604 South Dunmoor Drive

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Bruce V Crandall

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	widowed

6.(b) Name of ~~husband or~~ wife Minnie B Crandall

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 16, 1873

8. AGE: Years	Months	Days	If less than one day
72	1	3	....hrs. ....min.

9. Birthplace Michigan

(Town, county, and state)

10. Usual occupation Retired

11. Industry or business —

FATHER 12. Name Lattan A. Crandall

FATHER 13. Birthplace New York

MOTHER 14. Maiden name Mary Nichols

MOTHER 15. Birthplace New York

16. Informant Willard S Crandall

Address 10,604 So. Dunmoor Dr., S.S.

17. Cremation Date thereof Nov. 20, 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Fort Lincoln

Location Bladensburg Rd., Md.

18. Funeral director Warner & Pumphrey

Address Silver Spring, Md.

19. Nov 20 1945 Josephine McKhaffe

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19, 1945 at ..... P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1943 to Nov 19 1945

and that I last saw him alive on Nov 19 1945

Immediate cause of death	DURATION
Malaria (quartan)	5 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE John N. Andrews M.D.

M. D. or other

Address 9601 Colesville Rd Silver Spring, Md. Date signed 11-20 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 8370

11174

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

County: MONTGOMERY

City or town: SILVER SPRING.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

~~Hospital, institution, or~~ street address where death occurred:
9206 OLD BLADENSBURG ROAD.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: OHIO County: MEDINA.

City or town: WADSWORTH
(If outside city or town limits, write RURAL and give nearest town)

Street No. 107 PINE ST
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: MARIO CRISAFULLI

3.(b) Social Security Number: 282-09-8663.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of ~~husband or~~ wife: MARY.

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): MARCH 5TH 1876.

8. AGE: Years	Months	Days	If less than one day
69	8	5.	hrs. min.

9. Birthplace: ITALY.
(Town, county, and state)

10. Usual occupation: RETIRED

11. Industry or business

FATHER
12. Name: JOSEPH CRISAFULLI.
13. Birthplace: ITALY.

MOTHER
14. Maiden name: MARY PALELLA.
15. Birthplace: ITALY

16. Informant: ALLESANDRO CRISAFULLI. (SON)
Address: 9206 OLD BLADENSBURG RD

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: NOV 13 1945
(month) (day) (year)

Cemetery or ~~crematory~~: FORT LINCOLN.

Location: PRINCE GEORGE'S CO MD.

18. Funeral director: Warner E Pumphrey

Address: 8434 Ga Ave - Silver Spring - Md

19. NOV. 12 1945 (Date rec'd by registrar) Josephine M Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: NOV 10 1945 at 12:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from NOV 10 1945, to NOV 10 1945 and that I last saw him alive on NOV. 10 1945.

	DURATION
Immediate cause of death: Cerebral Hemorrhage	3 hours
Due to:	
Due to:	
Other conditions: Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John H Andrews M.D. M. D. or other

Address: 960 Colesville Rd Silver Spring, Md Date signed: 11-11 45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (12HE)

11175

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5418 Edgemoor Lane
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Montgomery
City or town: Bethesda, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 5418- Edgemoor La,
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Isabelle O. Crosser

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Robert Crosser
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb 11, 1876

8. AGE: Years	Months	Days	If less than one day
69			....hrs. ....min.

9. Birthplace: Cleveland, Ohio.
(Town, county, and state)
10. Usual occupation: At Home
11. Industry or business

FATHER
12. Name: William S. Hogg
13. Birthplace: Scotland

MOTHER
14. Maiden name: Isabelle Templeton
15. Birthplace: Scotland

16. Informant: Mrs Chas Sweeney
Address: 5418- Edgemoor La, Bethesda, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 11/19/45 (month) (day) (year)
Cemetery or crematory
Location
18. Funeral director: The S. H. Haines Co
Address: 2901-14-st N.W. Wash, D.C.
19. 11/19 (Date rec'd by registrar) 19 45 Wm E Jolves Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 19 19 45 at 4:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 1- 19 45 to Nov 19 19 45
and that I last saw h[illegible] alive on Nov 19 19 45

Immediate cause of death	DURATION
Cardiac Failure	
Embolism Liver.	
Ascites — Carcinoma	
Due to: ?	
Rheumatoid Arthritis Deformans	
Due to: for 20 years	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Herbert O Mauligan M. D. or other
Address: 1332 Mass. Ave NW Date signed Nov 19, 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77-2)

CERTIFICATE OF DEATH

11176

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? five hours

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 3 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Va. County:

City or town: Arlington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3100 Lee Blvd.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: DAVIS, Frederick Dumont G. RT 2c V-6 USNR

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mrs. Charlotte F. Davis

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 13, 1912

8. AGE: Years	Months	Days	If less than one day
33	7	21	hrs. min.

9. Birthplace: Brooklyn, N. Y.
(Town, county, and state)

10. Usual occupation: Navy

11. Industry or business:

FATHER
12. Name: H. F. D. Davis, Captain USN
13. Birthplace: Canada

MOTHER
14. Maiden name: Hazel Grant
15. Birthplace: New York

16. Informant: Wife: Mrs. Charlotte F. Davis
Address: 3100 Lee Blvd., Arlington, Va.

17. burial (Burial, cremation, or removal. Which?) Date thereof 11-6-45 (month) (day) (year)

Cemetery or crematory: Arlington National
Location: Arlington, Va.

18. Funeral director: Geo. W. Wise, J.C.F.
Address: 2900 M St., N. W., Wash., D.C.

19. 11-5 (Date rec'd by registrar) 19 45 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3 November 19 45 at 6:18 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3 Nov. 19 45, to 3 Nov. 19 45 and that I last saw him alive on 3 Nov. 19 45

Immediate cause of death	DURATION
Myocard. Atrophy, Coronary	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: unknown Date of 11-5-45

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank J. Brockhaus M.D. M. D. or other

Address: Gettysburg, Md. Date signed 11-5-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

11177

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Montgomery
City or town Kensington
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 33 years
Hospital, Institution, or street address where death occurred:
26 Fawcett
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Monty
City or town Kensington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 26 Fawcett
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME Benjamin Franklin Dierdorf

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

8.(b) Name of husband or wife Pearl Adams Dierdorf
6.(c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) March 31, 1878

8. AGE: Years 67 | Months 7 | Days 7 | If less than one day ... hrs. ... min.

9. Birthplace Pittsburg, Penna. (Town, county, and state)

10. Usual occupation Retired

11. Industry or business U. S. Government

FATHER 12. Name William Dierdorf
13. Birthplace Germany

MOTHER 14. Maiden name Anna Haeffer
15. Birthplace Penna.

16. Informant Miss Virginia Dierdorf
Address 26 Fawcett St. Kensington Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/9/45 (month) (day) (year)
Cemetery or crematory Rockville Union Cem.
Location Rockville, Md.

18. Funeral director Wm Reuben Humphreys
Address Bethesda, Md.

19. 11/7 1945 (Date rec'd by registrar) Wm E. Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7 1945, at 4:A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 4 1945, to Nov. 7 1945
and that I last saw him alive on Nov. 6 1945

Immediate cause of death	DURATION
Coronary Thrombosis	3 days
Due to	
Due to	
Other conditions Bifateral femoral thrombosis	—

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Benjamin Bernstead M.D.
M. D. or other
Address Silver Spring, Md. Date signed 11/7/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17)

CERTIFICATE OF DEATH

11178

Reg. Dist. No. 2-6

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Suburban Hospital
How long in hospital or institution? Dead on Arrival

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Commerce Lane
(If rural, give LOCATION)
2.(a) If veteran, name war: World War II 33897403

3. (a) FULL NAME: Willie Vernon Dove

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Mabel

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 11, 1923

8. AGE: Years	Months	Days	If less than one day
22	8		..... hrs. ..... min.

9. Birthplace: Montgomery Co. Md. (Town, county, and state)
10. Usual occupation: Private in Army
11. Industry or business
FATHER 12. Name: Reuben Dove
FATHER 13. Birthplace: Mont. Co. Md.
MOTHER 14. Maiden name: Florence Hagan
MOTHER 15. Birthplace: Mont. Co. Md.
16. Informant: wife
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-15-45 (month) (day) (year)
Cemetery or crematory: Lincoln Park Cem
Location: Rockville, Md.
18. Funeral director: Robert L. Snowden
Address: 246 N. Wash. St, Rockville
19. 11/15 (Date rec'd by registrar) 19 45 Wm E Jobe MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 11, 1945 at 7:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. Med. Exam 19 ..... to ..... 19 .....
and that I last saw h..... alive on ..... 19 .....

Immediate cause of death	DURATION
Hemorrhage	5 min.
Due to: stab wound in heart	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: .....
Date of op. .....
Autopsy results: same as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: homicide Date of 11-11-45
Where did injury occur? Rockville R.F.D. Monty Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury: stab wound Injured at work? no

23. SIGNATURE: Fred J. Bronhart M. D.
Dep. Med. Exam M. D. or other
Address: Frederick Md Date signed 11-11-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11179

Reg. Dist. No. 2 / 2

1. PLACE OF DEATH:

County: Montgomery

City or town: Poolesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 38 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Poolesville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: — not rural.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Catherine Elkins

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: Robert Elkins

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 9 - 1865

8. AGE:

Years	Months	Days	If less than one day
80	8	21	..... hrs. ..... min.

8. Birthplace: Washington, Va.

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: James Pickrell

13. Birthplace: Virginia

MOTHER — 14. Maiden name: Matilda Turner

15. Birthplace: Virginia

16. Informant: Mrs. Susanna Potter

Address: Poolesville, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/3/45 (month) (day) (year)

Cemetery or crematory: Monocacy

Location: Poolesville, Md

18. Funeral director: William B. Hilton

Address: Barnesville Md

19. Dec. 1 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 30th 1945 at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1945 to Nov 30 1945 and that I last saw h... alive on Nov. 29th 1945

	DURATION
Immediate cause of death: Myocarditis myocardial failure (acute)	1 week.
Due to: Cardio-vascular disease	10 yrs
Due to: Chronic myocarditis mitral regurgitation.	20 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE: Victor D. Young M.D.

M. D. or other

Address: Dawsonville Md P.O. Boyds Md Date signed: 12/12/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (720)

CERTIFICATE OF DEATH

11180

Reg. Dist. No. 214

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?:

Hospital, institution, or street address where death occurred:
805 Maple Ave.

How long in hospital or institution?:

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No. 937 Bonifant St.
(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: KATHERINE CLARK FENWICK

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: James B.

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 22nd. 1862

8. AGE: Years	Months	Days	If less than one day
83	7	9	..... hrs. ..... min.

9. Birthplace: Montg. Co. Md.
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business:

FATHER
12. Name: Oliver H. P. Clark
13. Birthplace: Montg. Co. Md.

MOTHER
14. Maiden name: Ann C. Coupard
15. Birthplace: Montg. Co. Md.

16. Informant: Miss Rose Mary Fenwick
Address: 937 Bonifant St. Silver Spg.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11 - 5 - 1945 (month) (day) (year)

Cemetery or crematory: St. Johns

Location: Forest Glen, Montg. Co. Md.

18. Funeral director: Wayne E. Pumphrey -

Address: 8434 Ga. Ave. Silver Spring, Md.

19. Nov. 4 1945 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 1 1945 at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1937 to Nov. 1 1945

and that I last saw h... alive on Nov 1 1945

	DURATION
Immediate cause of death: Acute Dilatation of Heart	5 min.
Due to: Rheumatic Endocarditis	40 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.:

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. B. Wardeyn M.D. (M. D. or other)

Address: 943 Bonifant St. Date signed 11-3-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (180)

CERTIFICATE OF DEATH

11181

Reg. Dist. No. 218

1. PLACE OF DEATH:
County: Montgomery
City or town: Gaithersburg (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 4 mo.
Hospital, institution, or street address where death occurred: —
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Gaithersburg (rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Ethel M. Frazier

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug 1 1945

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
	3	25		

9. Birthplace: Gaithersburg Monty Co Md
(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER
12. Name: Chas. L. Frazier
13. Birthplace: Sperryville Va

MOTHER
14. Maiden name: Jane Dodson
15. Birthplace: Sperryville Va

16. Informant: Floyd Frazier
Address: Rockville Md

17. Cremation
(Burial, cremation, or removal. Which?)
Date thereof: Nov. 28-1945
(month) (day) (year)
Cemetery or crematory: Baptist Church Cemetery
Location: Germantown, Md.

18. Funeral director: Chas. L. Frazier.
Address: Gaithersburg Md.

19. Nov. 27 1945 Edward G. Cooke
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 26 19 45 at 2:30 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov. Med. Exam 19 to 19
and that I last saw h alive on Exam 19

Immediate cause of death	DURATION
Burning (accidental)	died in burning fire
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

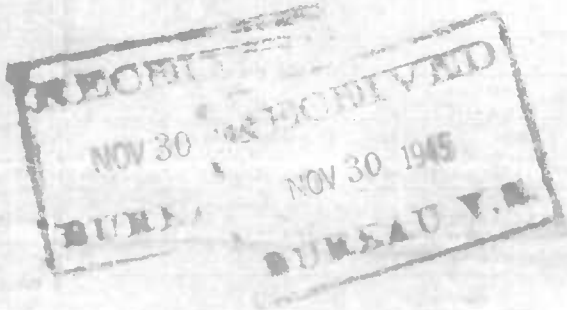
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 11-26-45
Where did injury occur? Gaithersburg (City or town) Monty (County) Md (State)
Injured at home, farm, industry, public place (where?): home
Means of injury: house fire Injured at work? no

23. SIGNATURE: Frank J. Bronhard M.D.
Dep. Med. Exam M. D. or other
Address: Gaithersburg Md Date signed: 11-27-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


RECEIVED
NOV 30 1945
BUREAU V.R.

STATE OF MARYLAND—CERTIFICATE OF DEATH

11182

M

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

1. PLACE OF DEATH

County Montgomery County Registration Dist. No. 213

Village or City Rockville, Maryland No. Chestnut Lodge St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 1 yrs. 5 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Mrs. Susan McGrath Gaskins If U. S. Veteran, specify WAR

(a) Residence: No. 4417 Georgia Ave, N.W. St., Ward. Washington, D.C.
(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
F	W	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of John R. Gaskins

6. DATE OF BIRTH (month, day, and year) Oct. 9, 1875

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	1	18	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Housewife

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Own home

10. Date deceased last worked at this occupation (month and year) Dec. 1943

11. Total time (years) spent in this occupation 45 +

12. BIRTHPLACE (city or town) Unknown
(State or country)

FATHER

13. NAME Unknown

14. BIRTHPLACE (city or town) "
(State or country)

MOTHER

15. MAIDEN NAME Unknown

16. BIRTHPLACE (city or town) "
(State or country)

17. INFORMANT Chestnut Lodge Sanitarium
(Address) Rockville, Md.

18. ~~BURIAL, CREMATION,~~ OR REMOVAL
Place Washington, D.C. Date Nov. 27, 1945

19. UNDERTAKER S. H. Hines Co.
(Address) 2901 - 14th St. N.W. Wash., D.C.

20. FILED 11/27/45, 19 Josephine D. Mallon
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH
November (Month) 27 (Day), 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from June 26, 1944, to November 27, 1945

I last saw h.. alive on November 27, 1945; death is said to have occurred on the date stated above, at 3:50 P.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Coronary Thrombosis	11/27/45
Other Contributary Causes of Importance:	
Generalized arteriosclerosis	10 yrs.
Hypertensive cardio-vascular disease	2 yrs.

Name of operation None Date of

What test confirmed diagnosis? None Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur?
(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HDME, or in PUBLIC PLACE.

Manner of Injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No.

If so, specify

(Signed) Dan'l M Bullock M.D.

(Address) Rockville Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or at **home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and own **home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants**. A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

11183

Reg. Dist. No. 214

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
~~Hospital, Institution, or~~ street address where death occurred:
10,301 Georgia Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 10,301 Georgia Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: GEORGE GRAHAM GETTY

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: Louise Burr
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 24th. 1866

8. AGE: Years	Months	Days	If less than one day
79	2	4	..... hrs. ..... min.

9. Birthplace: Washington, D. C.
(Town, county, and state)
10. Usual occupation: Retired Farmer
11. Industry or business

FATHER
12. Name: George Washington Getty
13. Birthplace: Washington, D. C.

MOTHER
14. Maiden name: Elizabeth Stevenson
15. Birthplace: Virginia

16. Informant: Mr. Graham Getty
Address: 10,301 Ga. Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11/30/45 (mooth) (day) (year)
Cemetery or Crematory: ~~xxxx~~ Grace Church
Location: Ga. Ave. Silver Spring, Md.

18. Funeral director: Barnes & Pumphrey
Address: 8434 Ga. Ave. Silver Spring. Md.

19. Nov. 29 19 45 (Date rec'd by registrar) Josephine M. Schaffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 28 19 45, at 4:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 2 19 42, to Nov. 28 19 45
and that I last saw h~~im~~ alive on Nov. 27, 19 45 19 .....

Immediate cause of death	DURATION
Coronary Thrombosis	Sudden
Due to	
Due to	
Other conditions: Generalized arteriosclerosis	
Influenza	3 days.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: J. Marion Boyd Jr. M.D. M. D. or other
Address: Silver Spring Date signed: 11/28/45

MARYLAND STATE DEPARTMENT OF HEALTH

11184

2411 N. Charles St., Baltimore (58)

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 yrs —
Hospital, institution, or street address where death occurred: 9815 Old Georgetown Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Monty
City or town: Bethesda Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 9815 Old Georgetown Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Elizabeth L. Gittings

3.(b) Social Security Number:

4. Sex: Female (FEMALE)
5. Color or race: White
6.(a) Single, married, widowed, or divorced: married.
6.(b) Name of husband or wife: Thomas Morton
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Jan. 7, 1893
8. AGE: Years: 52 Months: 10 Days: 14 If less than one day: hrs. min.
9. Birthplace: Howard Co., Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Enos J. Davis
13. Birthplace: Howard Co. Md.
MOTHER 14. Maiden name: Emma London
15. Birthplace: Baltimore Md.
16. Informant: Mrs. Leo M. Gittings
Address: 9815 Old Georgetown Rd.
17. Burial. (Burial, cremation, or removal. Which?) Date thereof 11/24/45 (month) (day) (year)
Cemetery or crematory: Rock Creek Cemetery
Location: Wash., D.C.
18. Funeral director: Wm. Reuben Trumbrey
Address: Bethesda Md.
19. 11/24 19 45 Wm E. Jones (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 21, 1945, at 1:15 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 27 - 1943 to Nov 21 1945 and that I last saw h alive on Nov 21. 1945

Immediate cause of death	DURATION
Carcinoma of Breast	22 mo.
Due to: —	
Due to: —	
Other conditions: None —	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H. R. Donaldson M. D.
M. D. or other
Address: 1716 R.I. Ave. N.W. Date signed: Nov 21-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-d)

11185

CERTIFICATE OF DEATH

★ Reg. Dist. No. 213

1. PLACE OF DEATH:

County Montgomery

City or town Rockville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Rockville

(If outside city or town limits, write RURAL and give nearest town)

Street No. East Middle Lane

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Emma Lyles Gittings

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

8.(b) Name of husband or wife Henson V. Gittings

Rockville, Md. 6.(c) If alive, give age 68 years

7. Birth data of deceased (mo., day, yr.) July 16, 1881

8. AGE: Years	Months	Days	If less than one day
64			hrs. min.

8. Birthplace Washington D.C. (Town, county, and state)

10. Usual occupation Housekeeper

11. Industry or business

FATHER 12. Name Thomas Williams

13. Birthplace Culpeper, Va.

MOTHER 14. Maiden name Louise Jackson

15. Birthplace Hanover City, Va.

16. Informant Sadie Lyons (Sister)

Address Washington, D.C.

17. Burial (Burial, cremation, or removal—Which?) Date thereof NOV. 27, 1945 (month) (day) (year)

Cemetery or crematory Scotland Cemetery

Location Scotland, Maryland

18. Funeral director Robert L. Snouden

Address Rockville, Maryland

19. 11-27-45 Josephine D. Thalton

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23 1945, at 10 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 15 1945, to Nov. 23 1945; and that I last saw h[illegible] alive on Nov. 23 1945.

	DURATION
Immediate cause of death: Arteriosclerosis Cerebral myocarditis	2 yrs.
Due to: with terminal anuria,	
Due to: Intubation + myocardial failure	2 mos.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. —

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (Where?)

Means of injury Injured at work?

23. SIGNATURE Wm. R. Faulkner, M.D. M. D. or other

Address Rockville, Md. Date signed 11/27/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (117a)

CERTIFICATE OF DEATH

11186

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 29 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)

Street No. 202 Sheppard St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Laura Wright Graham

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Horace L. Graham

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Sept 5 1858

8. AGE: Years	Months	Days	If less than one day
87	2	2	..... hrs. ..... min.

9. Birthplace: Wash DC
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business: —

FATHER
12. Name: Benj C Wright
13. Birthplace: Va

MOTHER
14. Maiden name: Martha Klopper
15. Birthplace: Wash DC

16. Informant: Claudia Graham Sisters
Address: 202 Sheppard St. Chevy Chase

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 10-45 (month) (day) (year)

Cemetery or crematory: Glenwood Cemetery

Location: Washington D.C.

18. Funeral director: Martin W. Hysong Co.

Address: 1300 K St. NW Washington DC

19. 11/7 (Date rec'd by registrar) 1945 Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 7 1945 at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 31 1945 to Nov 7 1945 and that I last saw h... alive on Nov 7 1945

Immediate cause of death	DURATION
Gastric Hemorrhage	2 min dead
Due to: Gastric ulcer	Unknown
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Frank J Brochard M.D. M. D. or other

Address: Gaithersburg Md Date signed: 11-7-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

11188

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Monty.

City or town Chevy Chase Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 wks —

Hospital, Institution, or street address where death occurred: 4519 Walsh St. Ch. Ch.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Monty

City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4519 Walsh St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Emma Louise Gustaveson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 13, 1859

8. AGE: Years	Months	Days	If less than one day
86			hrs. min.

9. Birthplace New York City
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Edward Gustaveson

13. Birthplace Sweden

MOTHER 14. Maiden name Mary Goodwin

15. Birthplace New York City

16. Informant Mrs. Chas. J. Whydon

Address 4519 Walsh St. Ch. Ch.

17. Shipment (Burial, cremation, or removal. Which?) Date thereof 11/24/45 (month) (day) (year)

Cemetery or crematory Woodlawn Cem

Location New York

18. Funeral director Wm Reuben Pumphrey

Address 7557 Wis. Ave. Bethesda, Md

19. 11/24 1945 Wm E. Gobel Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/29/45 19 at 10:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/18 19 45 to 11/23 19 45 and that I last saw h alive on 11/18 19 45

Immediate cause of death	DURATION
Coronary Thrombosis	30 minutes.
Due to Arterio sclerotic Heart disease	8 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Bruce Benjamin M.D.
M. D. or other

Address Bethesda, Md Date signed 11/24/45.

11189

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (57)

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:
County: Montgomery
City or town: Takoma Park - Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 days
Hospital, Institution, or street address where death occurred:
Washington Sanitarium
How long in hospital or institution? 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Bethesada
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4625 S. Chelsea Lane
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs Iona Hager

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed.

6.(b) Name of husband or wife: Birt E. Hager
6.(c) If alive, give age: Deceased years

7. Birth date of deceased (mo., day, yr.): Oct. 21 1870

8. AGE: Years	Months	Days	If less than one day
75		16	hrs. min.

9. Birthplace: Columbus - Nebraska
(Town, county, and state)
10. Usual occupation: House wife
11. Industry or business:
FATHER 12. Name: George Barnum
13. Birthplace: unknown
MOTHER 14. Maiden name: Carolina Kimbelle
15. Birthplace: Ill.
16. Informant: Washington Sanitarium Records
Address: Tk. Park, Md.
17. Shipment. Date thereof 11/7/45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Bellevue Cem
Location: Columbus, Neb.
18. Funeral director: Wm Reuben Gumphrey
Address: Bethesda Md
19. Nov. 7 1945 J Hudson Hodd
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11/6 1945 at 12:45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1941 to 11/6 1945
and that I last saw her alive on 11/6 1945

Immediate cause of death	DURATION
Brain Tumor: Neuro fibroma of questionable malignancy. Of left eighth	1½ years
Due to nerve. Duration: probably 1½ years. C.W.B.R.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Bruce T. Bairnsfather M.D.
M.D. or other
Address: Bethesda, Md Date signed 11/6/45

RSA

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

11509

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mos. 27 days

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 2 mos. 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5521 Kansas Avenue, N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war: 1st W.W.

3.(a) FULL NAME: HECHINGER, Pauline (n)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W--US	married

8.(b) Name of husband or wife: Sidney L. Hechinger

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 17 September 1901

8. AGE: Years	Months	Days	If less than one day
44	1	27	..... hrs. ..... min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business:

FATHER
12. Name: Max Needle
13. Birthplace: Russia (deceased)

MOTHER
14. Maiden name: Fanny Needle
15. Birthplace: (deceased) England

16. Informant: husband: Mr. Sidney L. Hechinger
Address: 5521 Kansas Avenue, N.W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 11-15-45 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Va.

18. Funeral director: B. Danzansky B Danzansky

Address: 3501 14th St., N. W., Wash., D.C.

19. 11-14 (Date rec'd by registrar) 19 45 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 14 November 1945, at 6:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 17 Aug. 1945, to 14 Nov. 1945 and that I last saw her alive on 14 Nov. 1945

Immediate cause of death	DURATION
Bronchopneumonia	4 days.
Due to	
Due to	
Other conditions: Metastatic Carcinoma, Skull (Primary - Breast Carcinoma, 1940) (Include pregnancy within 3 months of death)	6 months

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Harriet J. Davis Lt(MC)USNR
M. D. or other

Address: US N.H., Bethesda, Md. Date signed 11/14/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (42)

11190

CERTIFICATE OF DEATH

Reg. Dist. No. 213-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Moulgomery
City or town Rural - Near Rockville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Moulgomery
City or town Rural - near Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Glen Rd - R.F.D. # 1 - Rockville
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Susanna Elizabeth Henderson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Edward C. Henderson
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): September 6 - 1857

8. AGE: Years 88 | Months 2 | Days 22 | If less than one day ..... hrs. ..... min.

9. Birthplace: Highland - Howard Co - Md
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own Home

FATHER
12. Name: Snowden Thompson
13. Birthplace: Howard Co - Maryland

MOTHER
14. Maiden name: Mary Neef
15. Birthplace: Germany

18. Informant: Mrs. J. Lee Flagg - Granddaughter
Address: R.F.D. # 1 - Rockville - Maryland

17. Burial (Burial, cremation, or removal, Which?) Date thereof Dec 1 - 1945 (month) (day) (year)
Cemetery or crematory: St. Mary's Catholic Cem -
Location: Near Rockville - Maryland
18. Funeral director: Wm. Reuben Pumphrey
Address: Rockville - Maryland

19. 11/29/45 (Date rec'd by registrar) Josephine D. Hoallon Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 28 November 19 45 at 5 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 27 November 19 45 to 28 Nov. 19 45
and that I last saw h. alive on 27 Nov 45 19

Immediate cause of death	DURATION
Coronary Thrombosis	12 hrs
Due to: General Arteriosclerosis	30 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE W S Murphy M.D.
M. D. or other
Address: Rockville Md Date signed 28 Nov 45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-D)

11191

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery Co.

City or town Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months

Hospital, Institution or street address where death occurred: Suburban Hospital

How long in hospital or institution? 2 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1908 Stratton Rd., Silver Springs
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mrs Florence Hildebrandt

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) ~~Single, married~~, widowed, or ~~divorced~~
F	White	

6. (b) Name of husband ~~or wife~~ Wm. Hildebrandt

Deceased 6. (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 15, 1857

8. AGE: Years	Months	Days	If less than one day
88	9	5	..... hrs. ..... min.

9. Birthplace Anne Arundel Co, Maryland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business "

FATHER
12. Name Thomas Tydings
13. Birthplace ? md.

MOTHER
14. Maiden name Rachel Tydings
15. Birthplace ? ~~Anne Arundel Co~~ md.

16. Informant Thomas Hildebrandt (son)
Address 730 Woodward Bldg., Wash, DC

17. Removal (Burial, cremation, or removal. Which?) Date thereof Nov. 20-45 (month) (day) (year)

Cemetery or crematory

Location Baltimore Md.

18. Funeral director Warner E. Gumphrey

Address 8434 Ga ave Silver Spring Md.

19. 11/20 19 45 Wm E Jobes
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-20-45 19 45 at 3 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 21, 1945 to Nov. 20, 1945 and that I last saw h~~er~~ alive on Nov. 19, 1945.

	DURATION
Immediate cause of death acute myocardial insufficiency	2 days.
Due to chr. arteriosclerosis	15 years
Due to	
Other conditions diaphragmatic hernia	15 years.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. L. Davenport M.D.
M. D. or other

Address Bethesda, Md. Date signed 11/20/45.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for the change of age is shown on Film G 99 11-26-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 7a

CERTIFICATE OF DEATH

11192

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Tenn. County:

City or town:
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rt. #1 Newburn,
(If rural, give LOCATION)

2.(a) If veteran, name war: V

3.(a) FULL NAME: HOBBS, Robert Leaon, S1c V-6 USNR

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 16 June 1924

8. AGE: Years	Months	Days	If less than one day
21 ~~20~~	4	29	hrs. min.

9. Birthplace: Tenn. (Town, county, and state)

10. Usual occupation: Navy

11. Industry or business

FATHER
12. Name: Lou Berry Douglas Hobbs
13. Birthplace: Tenn.

MOTHER
14. Maiden name: Bessie Wright
15. Birthplace: unknown

16. Informant: father: Mr. Lou B.D. Hobbs
Address: Rt. #1, Newburn, Tenn.

17. removal (Burial, cremation, or removal. Which?) Date thereof 11-15-45 (month) (day) (year)

Cemetery or crematory: Rehobeth Cemetery

Location: Rt. #1 Newburn, Tenn.

18. Funeral director: Geo. L. Wise, J.C.F.

Address: 2900 M St., N. W., Wash., D.C.

19. 15 Nov. 45 (Date rec'd by registrar) 19 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 15 November 19 45 at 1:38A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 17 October 19 45 to 15 Nov. 19 45 and that I last saw h in alive on 15 Nov. 19 45

	DURATION
Immediate cause of death: Acute myeloid leukemia	4 months
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: M. Kemp Lt. (S) USN
M. D. or other

Address: U.S.N.H., Bethesda, Md. Date signed 11-15-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23-d)

CERTIFICATE OF DEATH

11193 216

Reg. Dist. No.

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? one month, 28 days

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Pa County:

City or town: Pittsburgh
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 6979 Lemington Avenue, Pitts., Pa.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: HOLLAND, Richard John, SM3c USCGR

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 15 April 1925

8. AGE:	Years	Months	Days	If less than one day
	20	5	28	hrs. min.

9. Birthplace: Pa.
(Town, county, and state)

10. Usual occupation: U.S. Coast Guard Reserve

11. Industry or business

FATHER
12. Name: Patrick Holland
13. Birthplace: Pa. (dec)

MOTHER
14. Maiden name: Elizabeth Cronin
15. Birthplace: Pa.

16. Informant: mo: Mrs. Elizabeth Holland
Address: 6979 Lemington Avenue, Pittsburgh, Pa.

17. removal (Burial, cremation, or removal. Which?) Date thereof: 11-25-45 (month) (day) (year)

Cemetery or crematory:

Location: Pittsburgh, Pa.

18. Funeral director: Geo. W. Wise JCJ
Address: 2900 M St., N. W., Wash., D.C.

19. 11-25-45 (Date rec'd by registrar) 19 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 24 Nov. 1945 at 8:20P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 26 Sept. 1945 to 24 Nov. 1945 and that I last saw h im alive on 24 Nov. 1945

Immediate cause of death	DURATION
Aplastic anemia	3 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: N. F. KEMP, Lt.Cdr. (MC) USNR
M. D. or other

Address: USNH Bethesda, Md. Date signed: 11-25-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

11194

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

CERTIFICATE OF DEATH

★ Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 31 days

Hospital, institution, or street address where death occurred:
Washington Sanitarium

How long in hospital or institution? 31 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6900 Arlington Road
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Fred W Horton

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Wh-	married

6.(b) Name of husband or wife: Mrs. Margaret Horton

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 3, 1883

8. AGE: Years	Months	Days	If less than one day
62	9	21	..... hrs. ..... min.

9. Birthplace: Ipswich, Mass-
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business:

FATHER
12. Name: Joseph T. Horton
13. Birthplace: Mass.

MOTHER
14. Maiden name: Caroline Winbergh
15. Birthplace: Mass

16. Informant: Washington Sanitarium Records
Address: Takoma Park, Maryland

17. Removal
(Burial, cremation, or removal. Which?)
Date thereof: Nov. 26, 1945
(mooth) (day) (year)

Cemetery or crematory: —

Location: Ipswich, Mass

18. Funeral director: Wm Gawler Sons

Address: Bethesda

19. Nov 24 1945
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 24 1945, at 10:05 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1942, to Nov. 24 1945

and that I last saw him alive on Nov. 24, 1945

	DURATION
Immediate cause of death: Thrombosis	Terminal
Due to: Leukemia (Myelogenous)	1 yr. 9 mos
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Robert A Hare M.D.
M. D., or other

Address: Takoma Park, Md. Date signed: 11/24/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

11195

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 hours

Hospital, Institution, or street address where death occurred:
US NAVAL HOSPITAL, Bethesda, Md.

How long in hospital or institution? 24 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County: Washington

City or town:
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4103 Oliver Street, Chevy Chase
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: HUMPHREYS, Julia Josephine

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W-US	married

6.(b) Name of husband or wife: Comdr. Lincoln Humphreys

USN Ret. Inact. 6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 8, 1896

8. AGE: Years	Months	Days	If less than one day
49			hrs. min.

9. Birthplace: St. Paul, Minn.
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business:

FATHER
12. Name: Charles Youngquist
13. Birthplace: Sweden

MOTHER
14. Maiden name: Helda Josephine Lantz
15. Birthplace: Sweden

16. Informant: Comdr. Lincoln Humphreys, USN Ret. Inact.
Address: 4103 Oliver St., Ch.Ch., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 11-26-45 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: Geo. W. Wise J.C.T.
Address: 2900 M Street, N. W., Wash., D.C.

19. 11-23-45 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 22 Nov. 1945 at 10:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 21 Nov. 1945 to 22 Nov. 1945 and that I last saw h 34 alive on 22 Nov. 1945

	DURATION
Immediate cause of death: Cerebral Hemorrhage	24 hours
Due to: Hypertension, Arterial	4 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.:

Autopsy results: Not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Gordon R. Spaul M. D. or other

Address: U.S. Nav. Hospital, Bethesda, Md. Date signed: 11/24/45

11196

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1946)

CERTIFICATE OF DEATH

Reg. Diat. No. 217

1. PLACE OF DEATH:

County Montgomery

City or town Olney, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

The Montgomery County General Hospital

How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. R # 2 Duc.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Emma Jackson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	

8.(b) Name of husband or wife

8.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 24, 1884

8. AGE: Years	Months	Days	If less than one day
61	0	20	hrs. min.

9. Birthplace Colesville, Montgomery Co., Maryland (Town, county, and state)

10. Usual occupation Housework.

11. Industry or business

FATHER 12. Name George Smith

13. Birthplace Montgomery Co., Md.

MOTHER 14. Maiden name Laura Johnson

15. Birthplace Montgomery Co., Md.

16. Informant Hospital records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 17 1945 (month) (day) (year)

Cemetery or crematory Good Hope Cem.

Location Colesville, Md.

18. Funeral director R. L. Snowden

Address Rockville, Md.

19. 11-16 1945 Gertrude B. Lamb

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14 19 45, at 8:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 4 1945, to Nov. 14 1945 and that I last saw h.e.r. alive on November 14 1945

Immediate cause of death	DURATION
Uraemia.	
Due to Acute Parenchymatous nephritis	
Due to Right Hydronephrosis due to stone in ureter	
Other conditions Cholelithiasis	

(Include pregnancy within 3 months of death)

Major findings of operations Stone in right ureter Date of op. 11/9/45

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE J. W. B.

M. D. or other

Address Sandy Spring, Md. Date signed 11/14/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

11197

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (58d)

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2½ days

Hospital, Institution, or street address where death occurred:

Bethesda Suburban Hospital

How long in hospital or institution? 2½ days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Rockville

(If outside city or town limits, write RURAL and giva nearest town)

Street No. Lincoln Park

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ethel Jackson.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Black.	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 6/13/36

8. AGE: Years	Months	Days	If less than one day
9	4	27	..... hrs. ..... min.

9. Birthplace Maryland. (Town, county, and state)

10. Usual occupation school girl

11. Industry or business

FATHER

12. Name Maurice Jackson.

13. Birthplace Maryland.

MOTHER

14. Maiden name Rosa Graham

15. Birthplace Maryland.

16. Informant Father

Address Rockville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 12, 1945 (month) (day) (year)

Cemetery or crematory Martinsburg Cem.

Location Martinsburg, Md.

18. Funeral director R. L. Dawson

Address 246. N. Wash. St. Rockville

19. 11-12-45 (Date rec'd by registrar) 19.....

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/9/45 at 8 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/6 1945, to 11/9 1945

and that I last saw h... alive on 11/9 1945

Immediate cause of death	DURATION
Acute Rheumatic Pancarditis.	
Due to	
Due to	
Other conditions Rheumatic arthritis Bronchopneumonia.	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Richard E. Kelly M. D. or other

Address 1834 Eye St. N.W. Date signed 11-9-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

11198

2411 N. Charles St., Baltimore 87a

CERTIFICATE OF DEATH

Reg. Dist. No. 316

1. PLACE OF DEATH:
County Montgomery
City or town Chevy Chase Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 yrs.
Hospital, Institution, or street address where death occurred:
32 East Bradley La.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montg.
City or town 32 East Bradley La.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Chevy Chase, Md.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Dwight Volney Jones

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married.

6.(b) Name of husband or wife Dorothy Jones
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 13, 1875

8. AGE: Years	Months	Days	If less than one day
70	6	6	..... hrs. ..... min.

9. Birthplace Reno, Nevada
(Town, county, and state)
10. Usual occupation Retired Real Estate Investments
11. Industry or business

FATHER
12. Name Joseph Jones
13. Birthplace Kentucky

MOTHER
14. Maiden name Mary Louise Allard
15. Birthplace Kentucky

16. Informant Mrs. Dorothy Jones
Address above address

17. Burial Date thereof 11/21/45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Rock Creek Cemetery
Location Washington, D.C.

18. Funeral director Wm Pickett Humphrey
Address 7557 Wis. Ave. Bethesda, Md.

19. 11/19 1945 Wm E. Jones
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19, 1945 at 4:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to Nov. 19, 1945 and that I last saw him alive on Nov. 19, 1945.

	DURATION
Immediate cause of death Central Lemorrhage	1 day
Due to Chr arteriosclerosis	5 years
Due to Diabetes Mellitus	15 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE E. G. Bamsfield M.D.
M. D. or other
Address Bethesda, Md. Date signed 11/20/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

11199

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 hrs - 25 min.
Hospital, institution, or street address where death occurred:
Suburban Hospital
How long in hospital or institution? 6 hrs. - 25 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Washington D.C. County
City or town D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6213 Vorlich Lane - Friendship Sta
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Velma May Jones

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	

6.(b) Name of husband or wife Henry C. Jones
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 7, 1903

8. AGE: Years	Months	Days	If less than one day
42	5	28	..... hrs. ..... min.

9. Birthplace Rantoule, Kansas
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Charles S. Powell
13. Birthplace ? Kansas

MOTHER
14. Maiden name Gertrude R. Munson
15. Birthplace Davis Co., Missouri

16. Informant Mr Henry C. Davis
Address 6213 Vorlich Lane - Wash. 16

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/7/45 (month) (day) (year)
Cemetery or crematory Potomac Cemetery
Location Potomac Maryland

19. Funeral director Lon Reuben Funeral
Address 7557 Wis. Ave. Bethesda Md.

19. 11/7 19 45 Wm E Jones Md.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 4 19 45 at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Cerebral apoplexy	5 hours
Due to Hypertensive arterial disease	2 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results Cerebral hemorrhage into left ventricle
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Edward Hugh M. D. or other
Address 1776 Eye St N W Date signed 11/14/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9341)

CERTIFICATE OF DEATH

11260

Reg. Dist. No. 214

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
9 Sussex Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 9 Sussex Road
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME: ANNA ROBERTSON LANDON

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Wallace P.
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 5th. 1864

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
81	1	17		

9. Birthplace: Barrie, Ontario, Canada
(Town, county, and state)
10. Usual occupation: Retired
11. Industry or business

FATHER
12. Name: James Robertson
13. Birthplace: Ireland

MOTHER
14. Maiden name: Annie Heart
15. Birthplace: Ireland

18. Informant: Mrs. John T. Lucker - daughter
Address: 9 Sussex Rd. Silver Spring.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 24 1945 (month) (day) (year)
Cemetery or crematory: Fort Lincoln
Location: Prince George's County, Md.

18. Funeral director: Warner & Pumphrey -
Address: 8434 Ga. Ave. Silver Spring. Md.

19. Nov. 23 1945 (Date rec'd by registrar) Josephine M Schaeffer (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 22 1945, at 2:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 27 1943 to Nov. 22 1945 and that I last saw h... alive on Nov. 15 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	6 Hours
Due to: Arteriosclerotic Heart Disease	5 Yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Harold Keegan MD M. D. or other
Address: Maryland Ave Date signed: 11/23/45

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

CHANGE OF RESIDENCE: letter from Dr. Little filed G99 12-18-45 LL

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

11201

CERTIFICATE OF DEATH

Reg. Diat. No. 223

1. PLACE OF DEATH:
County MONTGOMERY
City or town TACOMA PARK
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 MOS
Hospital, institution, or street address where death occurred:
805 MAPLE AVE.
How long in hospital or institution? 4 MOS.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State NEW JERSEY D.C. County [illegible]
City or town WASHINGTON
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2701 CONN AVE N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME MARY OLIVER LATTA

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	WIDOWED

6.(b) Name of husband or wife JAMES M LATTA
NOV 18 1855
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) 1855-

8. AGE: Years	Months	Days	If less than one day
90			..... hrs. ..... min.

9. Birthplace NEW YORK CITY
(Town, county, and state)
10. Usual occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name THOMAS OLIVER
13. Birthplace SCOTLAND

MOTHER
14. Maiden name MARIE ANNE MORRHEAD
15. Birthplace IRELAND

16. Informant [illegible] SELF
Address

17. Removed Date thereof Nov. 20 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Odd Fellows Cemetery
Location Burlington, N.J.
18. Funeral director Jos Gawler's Sons
Address 1756 Pa Ave N.W.
19. NOV. 20 1945 [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20, 1945, at 5:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 3, 1945, to Nov. 20, 1945
and that I last saw h.. alive on Nov. 19, 1945

Immediate cause of death	DURATION
arteriosclerosis	Indefinite
Due to (Congestive heart failure.)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [illegible] M.D.
M. D. or other
Address 6911 16th St. N.W. Washington, D.C. Date signed 11/20/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

11187

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery, Md.

City or town: Chevy Chase

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Five weeks

Hospital, institution, or street address where death occurred: 9305 Montgomery Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Dist of Col. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1040 Newton St. N.E.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Lennon, Charles Creen

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Lennon, Helena Schneider

6.(c) If alive, give age: 81 years

7. Birth date of deceased (mo., day, yr.): ~~Sept~~ Feb. 27. 1862

8. AGE: Years	Months	Days	If less than one day
83			....hrs. ....min.

9. Birthplace: (Town, county, and state)

10. Usual occupation: Druggist

11. Industry or business: Sale of Medicines

FATHER 12. Name: Jno. H. Lennon (LENNON)

13. Birthplace: Va.

MOTHER 14. Maiden name: Isabel Rudd

15. Birthplace: Va.

16. Informant: Rebecca I. Steffen

Address: 9305 Montgomery Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/14/45 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Suitland, Md.

18. Funeral director: Wm. Leis Sons Co

Address: 306-4 St. N.E. Wash. D.C.

19. 11/12 1945 (Date rec'd by registrar) Wm E Jolley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 12 1945, at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 15 1945, to Nov 12 1945, and that I last saw h.. alive on 11-10- 1945

Immediate cause of death	DURATION
Coronary Occlusion	12 hrs.
Due to: Arteriosclerosis	Years
Due to:	
Other conditions: Senility	2 Years

(Include pregnancy within 3 months of death)

Major findings of operations: 0

Date of op.:

Autopsy results: 0

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: John H. Brousseau M.D. M.D. or other

Address: Takoma Park Date signed: 11/12/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-2)

11202

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:
County Montgomery
City or town Washington Grove
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 26 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Monty
City or town Washington Grove (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Frederick Lowry

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Widowed

6.(b) Name of husband or wife Deceased
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 31 1855

8. AGE: Years	Months	Days	If less than one day
90	9	21	hrs. min.

9. Birthplace Taneytown - Rockbridge Co Va
(Town, county, and state)
10. Usual occupation Laborer
11. Industry or business Farmer
FATHER 12. Name Wm Lowry
13. Birthplace Va
MOTHER 14. Maiden name Sarah Southerman
15. Birthplace Va
16. Informant Geo Lowry
Address Washington Grove Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof NOV 26 1945 (month) (day) (year)
Cemetery or crematory St Johns Lutheran Cemetery
Location Church Hardy Co W.Va.
18. Funeral director Roy W. Barber
Address Laytonsville Md
19. NOV 24 1945 Alvin H Cook
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 22 1945 at 10:00 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 19 Dep. Med. Exam to Nov 19 and that I last saw h alive on Nov 19

Immediate cause of death	DURATION
Acute Cardiac Dilatation	½ hr.
Due to: Chronic Valvular heart disease	1 yr.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frank J. Brockard M.D.
Dep. Med. Exam
M. D. or other
Address Gaithersburg Md Date signed 11-23-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

11203

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County: Montgomery

City or town: Olney, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
The Montgomery County General Hospital Inc.

How long in hospital or institution? 1 Day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Sandy Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Donald Lynn

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Single.

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 27, 1899

8. AGE:

Years	Months	Days	If less than one day
45	11	1	..... hrs. ..... min.

9. Birthplace: Montgomery Co., Md.
(Town, county, and state)

10. Usual occupation: Labored

11. Industry or business: Farm

FATHER
12. Name: Joseph Lynn
13. Birthplace: Brookeville, Md.

MOTHER
14. Maiden name: Mary Carter
15. Birthplace: Oakdale, Md.

16. Informant: Hospital records
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 30, 1945 (month) (day) (year)

Cemetery or crematory: Sandy Spring Cem

Location: Sandy Spring, Md

18. Funeral director: R. L. Snowden

Address: 246 N. Wash St, Rockville, Md

19. 11-30- 1945 (Date rec'd by registrar) Geo. Edwin B. Lawson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 28 1945, at 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov-9- 1945, to Nov. 28 1945 and that I last saw h.. alive on Nov. 28 19..

	DURATION
Immediate cause of death: Influenza	2-
Due to: Lobar Pneumonia	19 days
Due to:	
Other conditions	

(Incinde pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Chas. B. Tumbleson
M. D. or other

Address: Sandy Spring, Md Date signed: 11/28/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (463) IX

11204

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 Months, 27 days

Hospital, Institution, or street address where death occurred:
U.S. Naval Hospital, Bethesda, Md.

How long in hospital or institution? 3 months, 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Calif. County:

City or town: Los Angeles,
(If outside city or town limits, write RURAL and give nearest town)

Street No. 816 S. Windsor Blvd.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mary Bartol MARTIN SMITH

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W-US	married

6.(b) Name of husband or wife: Comdr. Xavier MARTIN SMITH

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 27 Feb. 1895

8. AGE: Years	Months	Days	If less than one day
50	8	11	hrs. min.

9. Birthplace: Md.
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER
12. Name: George Bartol
13. Birthplace: Md. (deceased)

MOTHER
14. Maiden name: Nancy Rutledge Ramsey
15. Birthplace: Md. (deceased)

16. Informant: Comdr. Xavier MARTIN SMITH
Address: 8614 Lancaster Dr., Bethesda, 14, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 11-8-45 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: Joseph F. Birch's Sons

Address: 3034 M Street, N. W., Wash., D.C.

19. 11-8- 45 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8 Nov. 1945, at 12:36 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11 July 1945 to 8 Nov. 1945 and that I last saw h... in ...alive on 8 Nov. 1945

Immediate cause of death	DURATION
Hemorrhage	
Due to generalized abdominal carcinomatosis	bones.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results: Carcinomatosis, gastro-intestinal

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Michael R Reddish LCDR MC USN
M. D. or other

Address: U.S. Naval Hosp. Bethesda Date signed: 13 Nov. 45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (117a)

CERTIFICATE OF DEATH

11205

Reg. Dist. No. 716

1. PLACE OF DEATH:

County Montgomery

City or town Chevy Chase, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 days

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)

Street No. 110 Shepherd St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mr John P. McDonald

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) ~~Single~~, married, ~~widowed, or divorced~~
M	W.	

6.(b) Name of ~~husband or~~ wife Ella R. McDonald

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Mar. 18, 1878

8. AGE: Years	Months	Days	If less than one day
67	8	11	..... hrs. ..... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual occupation Sales executive

11. Industry or business American Oil Co.

FATHER 12. Name Thomas McDonald

13. Birthplace ? Ireland

MOTHER 14. Maiden name Agnes Stapleton

15. Birthplace ? Ireland

16. Informant Mrs. Ella R. McDonald

Address 110 Shepherd St. Ch. Ch. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/3/45 (month) (day) (year)

Cemetery or crematory Mt. Olivet Cemetery

Location Wash. D.C.

18. Funeral director Wm Reuben Pumphrey

Address Bethesda, Md.

19. 12/3 1945 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 29 1945 at 12 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1945, to Nov 29 - 1945

and that I last saw h~~im/er~~ alive on Nov 29 1945

Immediate cause of death	DURATION
Congestive heart failure	3 mos.
Due to Fracture, mam. vein, upper thigh	10 days
Due to Chr. myocarditis	
Due to	
Other conditions Ulcer of stomach	?
Diverticulosis of colon	?

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert Logan M. D. or other

Address 600 Newda N.W. Date signed Nov 29 1945

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83)

11206

CERTIFICATE OF DEATH

Reg. Dist. No. 212

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Clarksburg. B.F.D. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Clarksburg R.D. 10 (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Vernon T. McDonough

3.(b) Social Security Number: 2416-1533

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	Married

6.(b) Name of husband or wife: Rosie P. McDonough

6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): Dec 12-1873

8. AGE: Years: 69 Months: 11 Days: 5 If less than one day: hrs. min.

9. Birthplace: Dickerson, Montg. Co. Md. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER — 12. Name: Thomas McDonough

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Dickerson

15. Birthplace: Montgomery

16. Informant: Mrs. Rosie McDonough

Address: Clarksburg, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-19-45 (month) (day) (year)

Cemetery or crematory: Hyattstown Methodist

Location: Hyattstown, Md.

18. Funeral director: Wm. B. Hilton

Address: Barnesville Md.

19. Nov. 18 1945 (Date rec'd by registrar) Mrs. C. C. Hilton by Mrs. W. B. Hilton

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 17 1945, at 12 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 15 1945, to Nov 17 1945 and that I last saw h. im alive on Nov 15 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	4 days
Due to	
Due to Arteria sclerosis	5 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Ernest P. Roop M.D. M. D. or other

Address: New Market Md Date signed: Nov 17, 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

11207

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Rural Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State County

City or town Washington D.C.

(If ontside city or town limits, write RURAL and give nearest town)

Street No. 1607 - 17th St. N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Baby (Troy) McDowell

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	—

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 9 1945

8. AGE: Years | Months | Days | If less than one day: 9 hrs. 35 min.

9. Birthplace Rural Bethesda Md. Suburban Hosp. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name John Burdette McDowell

13. Birthplace Duncan, South Carolina

MOTHER 14. Maiden name Miriam Amylie Castles

15. Birthplace Jaffney, South Carolina

16. Informant Miriam Amylie McDowell

Address 1607 - 17th St. N.W. Wash., D.C.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof 11 - 12 - 45 (month) (day) (year)

Cemetery or crematory Suburban Hospital

Location 8600 Old Georgetown Rd. Bethesda, Maryland

18. Funeral director A. B. Salon, Asph

Address Suburban Hospital

19. 11/13/45 (Date rec'd by registrar) Wm E Jolley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10 1945, at 1:15 am M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 9 1945, to November 10 1945

and that I last saw h.i.m. alive on 11-9-45 19

Immediate cause of death	DURATION
Prematurity	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul Plank M.D. M. D. or other

Address 7425 Wisconsin Date signed 11/13/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (7)

CERTIFICATE OF DEATH

★ 11208 Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, ~~Institution, or street address~~ where death occurred: Suburban Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Montg.

City or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 8504 Hawley Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Alice R. Mc Kay

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband ~~or wife~~ William M. Mc Kay

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 14, 1876

8. AGE:

Years	Months	Days	If less than one day
68	11	16	..... hrs. ..... min.

9. Birthplace Washington, D.C. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

FATHER 12. Name William J. Clarke

FATHER 13. Birthplace England

MOTHER 14. Maiden name Sallie Richardson

MOTHER 15. Birthplace Kentucky

16. Informant Wm M. Mc Kay

Address 8504 Hawley Rd., S.S.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 3, 1945 (month) (day) (year)

Cemetery ~~or crematory~~ Fort Lincoln

Location Bladensburg Rd., Md.

18. Funeral director Maxnex E. Pumphrey

Address Silver Spring, Md.

19. 12/4 1945 Jm E Jones Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 30 1945 at 8 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 18 1945 to Nov. 30 1945

and that I last saw h~~e/she~~ alive on Nov. 30 1945

Immediate cause of death	DURATION
Hypostasis	
Due to Arterio-sclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE E. A. A. Dunn M. D. ~~or other~~

Address Bethesda Md. Date signed 11-30-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-01)

CERTIFICATE OF DEATH

11219 ✱ Reg. Dist. No. 7-16

1. PLACE OF DEATH:
County: Montgomery
City or town: Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Montgomery
City or town: Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 6516 Summit Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Edward V. Mendenhall

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W	M.

6.(b) Name of husband or wife: Mabel H.
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 24 1887

8. AGE: Years	Months	Days	If less than one day
58			hrs. min.

9. Birthplace: Pa (Town, county, and state)
10. Usual occupation: Sales Engineer
11. Industry or business: Wallace & Taylor

FATHER
12. Name: Jesse Mendenhall
13. Birthplace: Pa

MOTHER
14. Maiden name: Emma Mitchenbaugh
15. Birthplace: Pa

16. Informant: Mrs Mabel H Mendenhall
Address: 6516 Summit Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11/14/45 (month) (day) (year)
Cemetery or crematory: Ft Lincoln Cem.
Location: Md.

19. Funeral director: S H Hines Co.
Address: 2901 - 14th St. N W

19. 11/11 1945 (Date rec'd by registrar) Wm E. Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11 - 11 1945 at 3.45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 1944 to Nov 11 1945 and that I last saw him alive on 11 - 11 1945

Immediate cause of death	DURATION
Hypertensive Heart Disease - Renal Involvement	3 yrs.
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Jno. R. Huffman M. D. or other
Address: 17 Dupont Circle Wash DC Date signed: 11-11-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11210

(119-a)

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, Institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Gaithersburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. #2 - Walker St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Samuel Meridith Miller, jr.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	baby-

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) November 20, 1945

8. AGE: Years | Months | Days: 2 | If less than one day: ..... hrs. ..... min.

9. Birthplace Bethesda, Montgomery, Maryland (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Samuel Meridith Miller, sr.

FATHER 13. Birthplace Illinois

MOTHER 14. Maiden name Lillian Barr

MOTHER 15. Birthplace Stephenson, Michigan

16. Informant Hospital Records.

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 24-1945 (month) (day) (year)

Cemetery or crematory Arlington National Cemetery

Location Arlington Va

18. Funeral director W. W. Chambers Co

Address 1400 Chapin St N.W.

19. 11/23 1945 (Date rec'd by registrar) Wm E Dolan Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23- 1945, at 6 50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/22 1945 to 11/23 1945 and that I last saw h... alive on 11/22 1945.

	DURATION
Immediate cause of death Toxemia - due to Generalized Peritonitis	
Due to Intestinal Obstruction with perforation ileum	
Due to Omgenital Band Adhesion.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Peritonitis - Intestinal perforation - adhesion Date of op. 11/22/45

Autopsy results As above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Hubert H. Schonfeld M. D. or other

Address 1726 Eye St. N.W. - Wash. D.C. Date signed 11/23/45.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1121

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(122-B)

CERTIFICATE OF DEATH

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda (Rural) (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 38 days

Hospital, institution, or street address where death occurred: USNH, BETHESDA, MD.

How long in hospital or institution? 38 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Oregon County

City or town Salem (If outside city or town limits, write RURAL and give nearest town)

Street No. Route #1 (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME MOTT, James Wheaton, Congressman

3.(b) Social Security Number

4. Sex: male

5. Color or race: white

6.(a) Single, married, widowed, or divorced: married

6.(b) Name of husband or wife: Ethel L. MOTT

11-12-83

6.(c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) 11-12-83

8. AGE:

Years	Months	Days	If less than one day
62	0	0	hrs. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual occupation Congressman

11. Industry or business House of Representatives

FATHER 12. Name William S. Mott

13. Birthplace Pa.

MOTHER 14. Maiden name Willetta M. Bunn

15. Birthplace Pa.

16. Informant Deceased

Address Address as above

17. Removal (Burial, cremation, or removal. Which?) Date thereof 12 Nov. 45 (month) (day) (year)

Cemetery or crematory

Location Salem, Oregon

18. Funeral director Martin W. Hysong Co.

Address 1300 N St. N.W. Washington D.C.

19. 11-12-45 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 November, 1945 at 3:02 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5 October 1945, to 12 Nov. 1945

and that I last saw him alive on 12 November 1945

Immediate cause of death Thrombosis, Coronary, Acute — DURATION 1 hour

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings of operations obstruction intestinal sigmoid colon Date of op. 11-8-45

Autopsy results not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. E. Gilje Captain (MC) USN M. D. or other

Address USNH, BETHESDA, MD. Date signed 11-12-45

(11/14/45)

Evidence for change of cause of death is shown on FILM No. 100 JAN 11 1946 mcy

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-C)

CERTIFICATE OF DEATH

11212

Reg. Dist. No. 216

1. PLACE OF DEATH:
County # 6- E. Woodbine St.
City or town Ch. Ch. Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Montgomery
City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No. # 6 E. Woodbine St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME David Neumann

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Mary M.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 2- 1883

8. AGE: Years	Months	Days	If less than one day
62			..... hrs. ..... min.

9. Birthplace Wash. D. C. (Town, county, and state)
10. Usual occupation Gov. Official
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Germany

MOTHER
14. Maiden name Unknown
15. Birthplace Germany

16. Informant Margaret M. Neumann
Address 6- E. Woodbine St. ChCh. Md

17. Remove (Burial, cremation, or removal. Which?) Date thereof 6-11-45 (month) (day) (year)
Cemetery or crematory Cedar Hill Cemetery
Location 400 Suitland Rd. SE. Wash. D.C.
18. Funeral director The J. H. Sinnott Co.
Address 2901-14 St NW

19. 11-6-45 19..... (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 6- 19 45, at 4:25 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 18 19 45, to Nov 6 19 45
and that I last saw h.m. alive on Nov 4 19 45

Cause	DURATION
Immediate cause of death: Pericarditis with effusion	1 mo
Due to: Bronchogenic carcinoma, with involvement of the pericardium.	
Due to: Bronchiectasis.	6 mos
Other conditions: Pulmonary T.B. (Include pregnancy within 3 months of death)	6 "

Major findings of operations ..... Date of op. .....
Autopsy results Bronchogenic carcinoma.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Edward Reed, M.D. M. D. or other
Address 1720 Conn. Ave NW Date signed 11/6/45.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

5728

11213

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Suburban Hospital
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State D.C. County
City or town Washington (If outside city or town limits, write RURAL and give nearest town)
Street No. 4130 Legation St. N.W. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mrs. Alice O'Donnell

3. (b) Social Security Number

4. Sex Female
5. Color or race white
6.(a) Single, married, widowed, or divorced married
6.(b) Name of husband or wife Stanley
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) May 1, 1914
8. AGE: Years 30 Months 6 Days 22 If less than one day ... hrs. ... min.
9. Birthplace Washington D.C. (Town, county, and state)
10. Usual occupation Secretary
11. Industry or business

FATHER
12. Name John Ferrari
13. Birthplace Italy

MOTHER
14. Maiden name ?
15. Birthplace Italy

16. Informant Mr. Stanley M. O'Donnell
Address 4130 Legation St. N.W. D.C.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/26/45 (month) (day) (year)
Cemetery or crematory St. Marys Cemetery
Location Washington, D.C.
18. Funeral director Wm Reuben Pumphrey
Address 7557 Wis. Ave. Bethesda
19. 11/26 1945 (Date rec'd by registrar) Wm E Jones, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23 - 1945, at 4:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 21 1945, to Nov. 23 1945
and that I last saw her alive on Nov. 23 1945

Immediate cause of death	DURATION
Cerebral Vascular Disease with Hemorrhage	48 hr.
Due to	
Due to	

Other conditions Left Pulmonary Infarction; Right [illegible] (Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE Sidney B. Conner M.D. (M.D. or other)
Address [illegible] Date signed 11/24/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-2

CERTIFICATE OF DEATH

11214

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: MONTGOMERY
City or town: CHEVY CHASE
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MD. County: MONTGOMERY
City or town: CHEVY CHASE
(If outside city or town limits, write RURAL and give nearest town)
Street No.: # 8 LELAND ST.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: ELREANE W. PIPES

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	W

6.(b) Name of husband or wife: WALTER L.
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): MAY 2, 1886

8. AGE: Years	Months	Days	If less than one day
59			hrs. min.

9. Birthplace: WASH, D.C. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: WM. E. WILLIAMS
13. Birthplace: TENN.
MOTHER 14. Maiden name: ELLA A. HUSTON
15. Birthplace: N. J.
16. Informant: MRS JANE P. BRIGGS
Address: LANCASTER, PA.
17. Removal (Burial, cremation, or removal. Which?) Date thereof 11/28/45 (month) (day) (year)
Cemetery or crematory: ELIZABETH, N.J.
Location: " "
18. Funeral director: The S. H. Hines Co.
Address: 2901-14 St. N.W. Wash. D.C.
19. 11/28 19 45 (Date rec'd by registrar) M E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 28 19 45 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 19 45, to Nov 28 19 45
and that I last saw Deceased alive on Nov 27 19 45

Immediate cause of death	DURATION
Metastatic Carcinoma	12 mos
Primary, carcinoma of colon. Duration, 2 years.	
Due to: Carcinoma Colon	2 yrs.
Carcinoma Ovaries	
Due to:	
Other conditions: Tuberculosis of Eye.	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Elizabeth Chickering M.D.
M. D. or other
Address: 3601 Conn Ave Date signed 11-28-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

11215

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Monto

City or town: Friendship Hyts Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:
407 High St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Monty.

City or town: Friendship Hyts, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 407 High St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: William Henry Pyles

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married.

6.(b) Name of husband or wife: Susan M.

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 20, 1885

8. AGE: Years	Months	Days	If less than one day
60			hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business

FATHER — 12. Name: William H. Pyles

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Mary Levina

15. Birthplace: D.C.

16. Informant: Helen D. Pyles

Address: 407 High St. Friendship Hyts.

17. Buried (Burial, cremation, or removal. Which?) Date thereof Nov. 5 1945 (month) (day) (year)

Cemetery or crematory: Mt. Zion Cemetery

Location: Bethesda Md.

18. Funeral director: Wm Reuben Dempsey

Address: 7557 Wis. Ave. Bethesda

19. 11/5 1945 Wm E Jobes Md. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11/3/45 19 at 3:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 20 1945 to Nov. 3 1945 and that I last saw h.. l.m. alive on Sept 20 1945

Immediate cause of death	DURATION
Coronary occlusion	
Due to: Arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank Jagger Jr. M.D.
M. D. or other

Address: 8016 Georgetown Rd Date signed: 11/3/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (163-K)

11216

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 yrs

Hospital, institution, or street address where death occurred:
23 Denwood Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Monty

City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

Street No. 23 Denwood Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Ethan Allen Quackenbush

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Jessie Quackenbush

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): Feb 19 1875

8. AGE: Years	Months	Days	If less than one day
70	9	0	hrs. min.

9. Birthplace: Manning Neb. (Town, county, and state)

10. Usual occupation: Plumber

11. Industry or business

FATHER
12. Name: Wm Quackenbush
13. Birthplace: Unknown

MOTHER
14. Maiden name: Caroline Rose
15. Birthplace: Unknown

16. Informant: Jessie Quackenbush
Address: 23 Denwood ave. Takoma Pk.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 21, 1945 (month) (day) (year)

Cemetery or crematory: Forest Park Memorial Cemetery

Location: Riggs Rd. Hyattsville Md. Prince Geo. Co.

18. Funeral director: Linder & Faulks.

Address: 254 Carroll St. N.W. Takoma Park, D.C.

19. Nov. 19 1945 (Date rec'd by registrar) J. Nelson Todd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 19, 1945 at 1:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec Med. Exam. 19, to 19
and that I last saw h alive on Dec Med. Exam. 19

Immediate cause of death	DURATION
Asphyxia due to	3 min.
Inhaling gas	duration
Due to (suicide)	time.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: suicide Date of 11-19-45

Where did injury occur? Takoma Park (City or town) Monty (County) Md (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank J. Bouchart M.D. Dep. Med. Examiner M. D. or other

Address: Frederick Md. Date signed 11-19-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

11217

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 49(a)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery Co.

City or town Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mon. - 26 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4619 W. Va. Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs Henrietta Ragan

3.(b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
F	W.	

6.(b) Name of husband ~~or wife~~ Frank Ragan

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 15, 1890

8. AGE: Years	Months	Days	If less than one day
55	5	13	..... hrs. ..... min.

9. Birthplace Bris, Virginia
(Town, county, and state)

10. Usual occupation House Wife

11. Industry or business

FATHER 12. Name Milton Shifflett

13. Birthplace Bris, Virginia

MOTHER 14. Maiden name Fanny Knight

15. Birthplace Bris, Virginia

16. Informant

Address

17. ~~Removal~~ Burial (Burial, cremation, or removal. Which?) Date thereof 12-1-45 (month) (day) (year)

Cemetery or crematory Ft. Lincoln

Location Wash. D.C.

18. Funeral director W. W. Chambers Co.

Address 1400 Chapin St. N.W.

19. 11-29-45 (Date rec'd by registrar) 19 ..... W E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29, 1945 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 11 - 1945 to Nov 29, 1945 and that I last saw h.. alive on Nov. 28, 1945

Immediate cause of death	DURATION
Cerebral abdominal carcinomatosis	9 mo.
Due to Carcinoma of the ovary	1 yr.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings at operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE E. G. Bowersox 2d M. D. or other

Address Bethesda Md Date signed 11/29/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1248)

11218

CERTIFICATE OF DEATH

★ Reg. Dist. No. 216

1. PLACE OF DEATH:

County Suburban Hospital

City or town Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mon. - 26 days

Hospital, institution, or street address where death occurred:
9600 Old Georgetown Road - Bethesda Maryland

How long in hospital or institution? 1 mon. - 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Monty.

City or town Kensington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 30 Bladensburg Rd.,
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John D. Raney

3.(b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
M	White	M.

6.(b) Name of ~~husband or~~ wife Edna C. Raney

6.(c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) ? 1893

8. AGE: Years	Months	Days	If less than one day
52	9	26	....hrs. ....min.

9. Birthplace Kensington, Md. (Town, county, and state)

10. Usual occupation ? Manager Beer Distributor Agency

11. Industry or business ?

FATHER
12. Name James P. Raney
13. Birthplace ? Maryland

MOTHER
14. Maiden name Marianne Cutlin
15. Birthplace ? Maryland

16. Informant Mrs. Edna Raney
Address 30 Bladensburg Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/24/45 (month) (day) (year)

Cemetery or crematory Lt. Johns Cem.

Location Forest Glen, Maryland

18. Funeral director Wm Reuben Pumphrey

Address Bethesda, Md.

19. 11/24 1945 (Date rec'd by registrar) Wm E Jolley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-21-45 — 10 P.M. 1945, at 10 P. M. (30) (35)

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19.... to ....19....

and that I last saw h.... alive on ....19....

Immediate cause of death	DURATION
Terminal hypostatic pneumonia	
Due to Bronchiectasis complicated	
Due to Hepatic cirhosis.	
Other conditions Left diaphragmatic pleurisy.	

(Include pregnancy within 3 months of death)

Major findings of operations ....Date of op....

Autopsy results as above.

PHYSICIAN: Please underline the cause te which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.... Date of....

Where did injury occur? .... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ....

Means of injury Injured at work?

23. SIGNATURE Edward Heuck M.D.
M. D. or other

Address 1726 Eye St N.W. Date signed 11/27/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11162

Reg. Dist. No. 223-

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 years

Hospital, institution, or street address where death occurred:

Washington Sanitarium + Hospital

How long in hospital or institution? 15 yrs 1 mo 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. Washington San + Hospital

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Bettie Carter Smoot - Mrs W.a.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife William A.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 26, 1854

8. AGE: Years	Months	Days	If less than one day
90	11	3	..... hrs. ..... min.

9. Birthplace Charlestown Va.
(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name William McGuire

13. Birthplace Fredricksburg Va.

MOTHER 14. Maiden name Marrietta Weber Alexander

15. Birthplace King georges Town Va.

16. Informant Washington San + Hospital

Address Takoma Park - Wash 12, D.C.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Nov 30, 1945 (month) (day) (year)

Cemetery or crematory

Location Alexandria, Va.

18. Funeral director J. S. Eveily

Address 809 King St. Alex Va

19. Nov. 30 '45 (Date rec'd by registrar) J. Donaldson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/30 1945, at 3:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 27 1945, to Nov. 30 1945

and that I last saw her alive on Nov. 30 1945

Immediate cause of death	DURATION
Bronchio-pneumonia	4 days
Due to	
Due to	
Other conditions Senility	years

(Include pregnancy within 3 months of death)

Major findings of operations 0

Date of op.

Autopsy results 0

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John F. Brownberger M.D. M. D. or other

Address Takoma Park - DC Date signed 11/30/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 3-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (122-C)

11219

216

Reg. Dist. No.

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Va. County:

City or town: Alexandria
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3313 Coryell Lane, Park Fairfax
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: STOTT, Helen

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W-US	married

6.(b) Name of husband or wife: Captain George W. Stott, USN

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 9 April 1906

8. AGE: Years	Months	Days	If less than one day
39	—	—	hrs. min.

9. Birthplace: Washington (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business:

FATHER — 12. Name: Edwin Wallis Buckley
13. Birthplace: Wis.

MOTHER — 14. Maiden name: Katherine Frances Dilley
15. Birthplace: Missouri

16. Informant: Captain A. E. Buckley
Address: 4116 36th St., S., Arl., Va.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 11-24-45 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: P. J. Ives

Address: Arlington, Va.

19. 11-23- 1945 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 23 November 1945, at 6:40 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12 Nov. 1945, to 23 Nov. 1945 and that I last saw her alive on 23 Nov. 1945

Immediate cause of death	DURATION
Embolism cerebral	1 da
post-operative	
Due to	
Due to	
Other conditions Obstruction intestinal	11 da

(Include pregnancy within 3 months of death)

Major findings of operations: Obstruction intestinal due to fibrous band — Date of op. 11/18/45, 11/22/45

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Eilif C. Hanssen Capt (MC) USNR

Address: U.S. Naval Hosp. Bethesda Md. M. D. or other

24. Date signed: 11/26/45

RECEIVED
NOV 29 1945
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (242)

CERTIFICATE OF DEATH

11220

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 4226 East West Highway

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Montgomery

City or town: Bethesda Md Ward No.:

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 4226- East West Highway

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: John Tullis

3. (b) Social Security Number:

4. Sex: M

5. Color or race: W

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lucille

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1879

8. AGE: Years: 66 Months: Days: If less than one day: hrs. min.

9. Birthplace: Forest Ohio (Town, county, and state)

10. Usual occupation: Retired Clerk

11. Industry or business

FATHER

12. Name: Freeman Tullis

13. Birthplace: Ohio

MOTHER

14. Maiden name: Louisa Piper

15. Birthplace: Ohio.

16. Informant: Lucille Tullis

Address: 4226 - East West Highway

17. Burial, cremation, or removal. Which?: Burial Date thereof: Nov 15-45 (month) (day) (year)

Cemetery or crematory: Ft Lincoln

Location: Funeral Gen Co - Md

18. Funeral director: The S-H-Funeral Co

Address: 2901 - 14th St NW

19. 11/17 19 (Date rec'd by registrar) Wm E Johns Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov - 12 1945, at 6A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ~~Nov 11~~ Jan 1945, to Nov 12 1945; and that I last saw h~~e~~ alive on Nov Aug, 1945.

Immediate cause of death: Coronary Thrombosis

DURATION:

Due to: Congestive Heart Failure

Due to:

Other conditions: Cirrhosis of Liver.

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur?: (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. H. Thibadeau M.D. M. D. or other

Address: 317 - Ala. Ave. S.E. Date signed: 11-17-45

1939
85

1854
85

1939

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

11221

CERTIFICATE OF DEATH

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Montgomery
City or town: Glen Echo
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 yrs.
Hospital, institution, or street address where death occurred: 6505 Wiscasset Rd.,
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Glen Echo
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 6505 Wiscasset Road,
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: ELLIS A. ~~WITHCRAFT~~ WHITCRAFT.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife: Q. Marie
6.(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): November 9, 1869

8. AGE: Years	Months	Days	If less than one day
76	0	14	hrs. min.

9. Birthplace: Philadelphia, Pa.
(Town, county, and state)
10. Usual occupation: Retired
11. Industry or business

FATHER
12. Name: Ellis Everet Whitcraft
13. Birthplace: New Jersey

MOTHER
14. Maiden name: Sally Ebett
15. Birthplace: Penn.

16. Informant: Mrs. Marie Whitcraft
Address: 6505 Wiscasset Rd. Glen Echo

17. Cremation (Burial, cremation, or removal. Which?) Date thereof 11/26/45 (month) (day) (year)
Cemetery or crematory: Cedar Hill Cemetery
Location: Maryland

18. Funeral director: Lt. Reuben Pumphrey
Address: 7557 Wis. Ave. Bethesda, Md.

19. 11/26 1945 Wm E Jobe Registrar
(Date rec'd by registrar).

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 23 1945, at 1.05 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 17 1945, to Nov. 23 1945, and that I last saw h.. alive on Nov. 22 1945.

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to: Hypertension	
Due to: Arterio-sclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: E. A. A. Dunn M. D.
Address: Bethesda Md. Date signed 11-29-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186a)

CERTIFICATE OF DEATH

11222

Reg. Dist. No. 214

1. PLACE OF DEATH:
County Montgomery
City or town Takoma Park Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 days.
Hospital, Institution, or street address where death occurred:
Washington Sanitarium & Hospital
How long in hospital or institution? 16 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give resideoce of mother)
State Maryland County Montgomery
City or town Takoma Park Md.
(If outside city or towo limits, write RURAL aod give nearest town)
Street No. 805 Greenwood Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Bessie Celia Wilbourne

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widow

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 30, 1878

8. AGE: Years	Months	Days	If less than one day
67	7	20	..... hrs. ..... min.

9. Birthplace Desmoines Iowa
(Town, county, and state)

10. Usual occupation Government worker

11. Indusfry or business

FATHER 12. Name Alvin Elliott

FATHER 13. Birthplace Unk.

MOTHER 14. Maiden name Unk.

MOTHER 15. Birthplace Unk.

16. Intormant Records - Washington San. & Hosp.
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 23, 1945 (month) (day) (year)

Cemetery or crematory Arlington National

Location Washington, D.C.

18. Funeral director L. H. Hines Co.

Address 2401 - 14th St. N.W. Wash., D.C.

19. Nov 30 1945 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20, 1945, at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 3, 1945, to Nov 20 1945 and that I last saw h.. alive on Nov. 19 1945

	DURATION
Immediate cause of death Coronary Occlusion	1 hr ?
Due to Arteriosclerosis	?
Due to She fell from a chair, while cleaning her car,	
Other conditions Fracture Spine cusp. L.1 & T.12	

(Include pregnancy within 3 months of death)

Major findings of operations None - Body cast Applied by Dr Hall Date of op. 11-11-45

Autopsy results Refused by sister & coroner

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Accident Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, Indusfry, public place (where?) .....

Means of injury Accidental fall Injured af work?

23. SIGNATURE Lead N. Calver M.D.
M. D. or other

Address Silver Spring, Md Date signed 11-20-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

5115

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11223

★ Reg. Diat. No. 216

1. PLACE OF DEATH

County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Suburban Hospital

How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4410 Highlands Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Sally Wilson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: William

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 21, 1910.

8. AGE:

Years	Months	Days	If less than one day
35	6	7	..... hrs. ..... min.

9. Birthplace: Washington DC

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER

12. Name: Woodley Abell

13. Birthplace: Md.

MOTHER

14. Maiden name: Sara Russell

15. Birthplace: Md.

16. Informant: Mr. William K. Wilson

Address: 4410 Highland Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/1/45 (month) (day) (year)

Cemetery or crematory: Mt. Olivet Cemetery

Location: Wash. D.C.

18. Funeral director: Wm. Reuben Humphrey

Address: Bethesda, Md.

19. 12/1 (Date rec'd by registrar) 1945 Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11/28 1945, at 10:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1944 to Nov. 28 1945

and that I last saw her alive on 11/28 1945

Immediate cause of death	DURATION
Massive Mesenteric Thrombosis	3 days
Due to: Acute regional colitis	7 days
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Acute regional colitis involving cecum

Date of op. 11/20/45

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Bruce V. Benjamin, M.D.

M. D. or other

Address: Bethesda, 14, Md. Date signed: 11/28/45

VS A15 9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.